Minutes of MDPB Meeting July 21, 2004

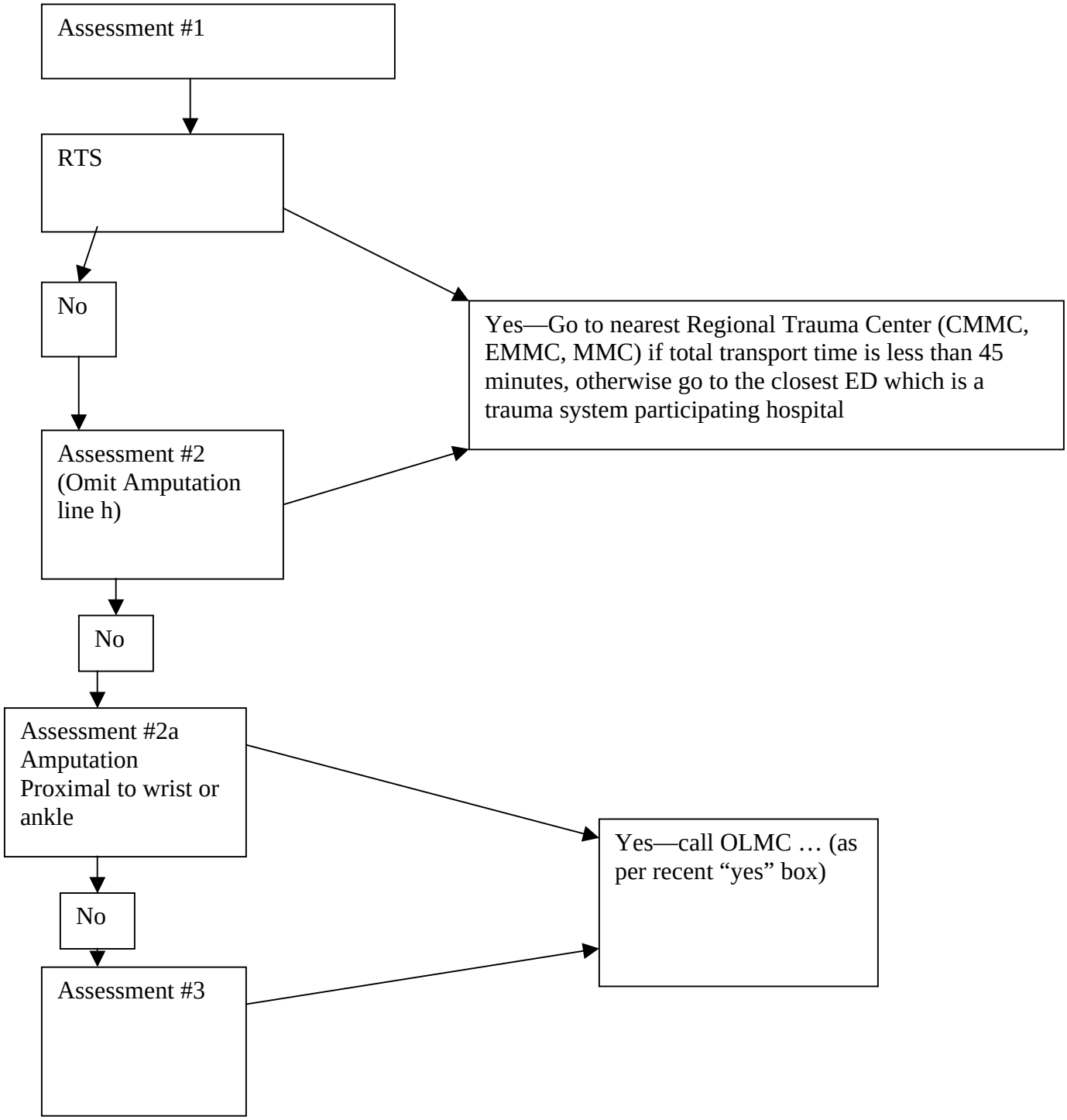
In Attendance: Bill Dunwoody, Dave McKelway, Paul Marcolini, Cathy Case, Joanne, LeBrun, David Stuchiner, Kevin Kendall, Eliot Smith, Jeff Regis, David Ettinger, Joe Lahood, David White, Scott French, Lori Metayer, Marcus Day, Rick Petrie, Dan Palladino, Jay Bradshaw, Dawn Kinney, Alan Azaara, Paul Liebow, Rob Tarbox, Mike Gibbs, Jim Caron, Norm Dinerman, Rhonda Chase, Jay Bradshaw, Steve Diaz

I. Acceptance of minutes of may 2004 with McKelway motion and second by Smith and unanimous acceptance.
II. Legislative Update by Bradshaw with shortfall expected in the future.
III. Maine EMS study is concluded and will be distributed widely once final editing for items such as spelling of names is completed.
IV. Protocols (using the Draft by Kinney as a reference)
    a. Page 20 Chest Pain-- requires a change so that Intermediates can give ASA without OLMC contact first—unanimous support
    b. Amiodarone—look to the CAC for recommendation
    c. Page 26 Cardiac Arrest or Arrhythmias—omit the added sentence under #3, and instead write “Do not withhold CPR while waiting for defibrillation equipment.”
    d. Page 63 Pain Management—4a. Delete morphine. Adopt fentanyl in language such as the following: “Fentanyl 25-50 micrograms IV push every 5 minutes titrated to effect with maximum dose of 200 micrograms, Contact OLMC if further dosing needed or if vital signs are not stable. Contact OLMC for pediatric dosing which is typically 0.25-1 microgram per kilogram IV in this setting.” Will need to change 5a as well and page 58 number 10.
    e. Page 66 Toxins—change Poison Control Number to 1-800-222-1222.
    f. Page 20 Chest Pain-- #4—Add “ALS back-up still mandatory despite use of ASA.” We agreed on this in concept and I look for member comment on this.
    g. Accept Dr. Liebow’s comments as typed by Diaz and given to Kinney—unanimous support.
    h. Need new Forward explanation for Intermediates. Regis will draft. The thought was that they now may act as an extension of the medic and perform within the intermediate scope of practice when advised to do so by a paramedic (the thought is if the paramedic would do a certain procedure, then the intermediate may help up to their trained license level). Intermediates may not work beyond their scope of practice and the paramedic must provide on-scene oversight throughout the patient interaction. As well, the paramedic must “tech” the call—they are primarily responsible for the patient. Run sheet signed by both the Intermediate and Paramedic. Also looking for a one year QI project attached to this. Unanimous approval.
    i. Benzodiazepines for seizures (Seizures page 43): Much discussion surrounding the use of Lorazepam, or Midazolam, or both. Final vote was

to accept both with 6:1 in favor—Stuchiner against with the concern of number of medicines in the drug box leading to an increased risk for medical error which was recognized—the issue is that lorazepam would be best but requires refrigeration and thus we needed another option. Sample language as follows:

i. " 11. B. Alternate routes to IV dosing:
    i. Intramuscular dosing—Midazolam 0.2 mg/kg IM if IV cannot be established to maximum dose of 10 mg.
    ii. Buccal administration: Midazolam 10 mg per buccal; Lorazepam 0.05-0.15 mg/kg per buccal
    iii. Rectal administration: Midazolam 0.3 mg/kg pr to a maximum dose of 10 mg (lorazepam is too slow here).

j. Page 59 Head Trauma: Accept as modified by Petrie/Case with the following changes: "2. O2 as appropriate and Airway Management per Blue 2 or 3. 3. If necessary…"
k. Page 48 Trauma Triage Protocol (see next page): I have just put a few words in each box to represent the total or show the exclusions.



Etc…

Schematically, this shows that a "yes" in box 1 or 2 qualifies as giving the crew the ability to go directly to a trauma center if less than a 45 minute transit and if patient does not require emergency stabilization in an ED, otherwise no change from previous

Motion by Stuchiner, second by Kendall; approved with a vote of 6:1 with Smith against.

l. Friendly amendment: Change page 51 beginning sentences to the following: “1. OLMC considers transport to RTC using following guidelines. a. if patient would best be served by RTC and less than 45 minutes in transport time, then OLMC may direct you to the RTC. b. if patient requires RTC but greater than 45 minute transport time or patient requires life saving interventions, patient to go to the closest ED.

Next meeting August 18, 2004—Diaz will e-mail out info re: the balance of today’s agenda.